

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2011
FORM APPROVED
OMB NO. 0938-0391

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|---|---|--|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155605 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/07/2011 | |
| NAME OF PROVIDER OR SUPPLIER GRANDVIEW HEALTH & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1959 E COLUMBUS ST MARTINSVILLE, IN 46151 | | | |
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| K 000 | <p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/07/11</p> <p>Facility Number: 000400 Provider Number: 155605 AIM Number: 100266880</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Grandview Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 80 and had a census of 65 at the time of this visit.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/13/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | K 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 025 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating for the ceiling in 1 of 2 mechanical rooms with natural gas fired water heaters. This deficient practice could affect any resident, staff or visitor in the vicinity of the mechanical room by the east nurse's station.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., the mechanical room by the east nurse's station which contains three natural gas fired water heaters had an eight inch diameter opening in the ceiling into the attic above the middle water heater. Based on interview at the time of observation, the Maintenance Director acknowledged the mechanical room by the east nurses' station had</p> | | | K 025 | | | |

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| K 025 | Continued From page 2 an eight inch opening in the ceiling into the attic. | | | K 025 | | | |
| K 029 SS=E | <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 doors serving hazardous areas such as laundry rooms are equipped with self closing devices on the door which securely latches into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the laundry room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., the laundry room corridor door by Room # 12 is equipped with a self closing device but it did not close and latch securely into the door frame. The laundry room corridor door by the east facility exit is not equipped with a self</p> | | | K 029 | | | |

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| K 029 | Continued From page 3 closing device but did latch securely into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the laundry room corridor door by Room # 12 self closed but did not latch into the door frame, and the laundry room corridor door by the east facility exit is not equipped with a self closing device. | K 029 | | | | | |
| K 038 SS=F | 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 7 of 7 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the | K 038 | | | | | |

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| K 038 | Continued From page 4 protected premises. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., all seven facility exit doors are equipped with electromagnetic locks which remained locked when the fire alarm was activated and silenced, but not reset at 1:15 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged all seven facility exit doors electromagnetic locks should have unlocked when the fire alarm was activated, then remained unlocked when the system was silenced but not reset. | | | K 038 | | | |
| K 076 SS=E | 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: | | | K 076 | | | |

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| K 076 | <p>Continued From page 5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from the weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect any resident, staff or visitor in the vicinity of the exterior oxygen supply location near the exit of the facility by Room #112.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 06/07/11 from 11:45 a.m. to 1:40 p.m., seven 180 liter liquid oxygen tanks were located in a exterior chain link enclosure outside the facility near the exit by Room # 112. The enclosure was not protected from sun, snow, or rain. Based on interview at the time of observation, the Maintenance Director acknowledged liquid oxygen storage tanks in the exterior oxygen supply storage location were exposed to all types of weather.</p> | | | K 076 | | | |
| K 144 SS=F | <p>3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> | | | K 144 | | | |

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| K 144 | <p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Generator Log Weekly/Monthly" documentation with the Maintenance Director during record review from 9:58 a.m. to 11:45 a.m. on 06/07/11, the emergency generator was run on a monthly basis for at least thirty minutes each month for the period of 12/02/10 through 05/24/11 but the the logs utilized by the facility did not record the time to transfer power from the main source to the emergency generator. Based on interview at the time of record review, the Maintenance Director acknowledged the transfer time to transfer power to the emergency generator was not recorded for each month.</p> | K 144 | | | |

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| K 144 | Continued From page 7 3.1-19(b) | | | K 144 | | | |